

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>004683</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/09/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH BEDFORD HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2900 W 16TH ST BEDFORD, IN 47421</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of one (1) State complaint at a Critical Access Hospital.</p> <p>Complaint number: IN00104657 Substantiated: No deficiencies cited.</p> <p>Date of survey: 4-9-12</p> <p>Facility number: 004683</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Indiana University Health Bedford Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 04/26/12</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1